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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised copy of the deficiencies was sent to the provider on 3/20/13.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility had a census of 54 residents with 10 residents reviewed for unnecessary medications.	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 329	Continued From page 1 Based on observation, interview and record review, the facility failed to ensure 2 of the 10 sampled residents did not receive unnecessary medications when the staff failed to attempt gradual dose reductions for residents receiving antidepressant therapy. (#48 and #4) Findings included: - Resident #48's 2/7/13 physician's orders included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The physician's orders included an order for Zoloft 100 mg (milligrams) orally every night with a start date of 10/21/10. Resident #48's 2/17/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident experienced severely impaired cognition, displayed no signs of depression, and received antidepressant medication for 7 of the 7 observation days. Resident #48's 2/26/13 care plan instructed staff to monitor the resident for adverse consequences and side effects such as suicidal ideation and mental status changes while the resident received Zoloft to treat depression. Review of resident #48's clinical record between December 2011 and March 2013 lacked evidence that the physician ordered a gradual dose reduction for the Zoloft originally started on 10/21/10	F 329		

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During an observation on 3/12/13 at 3:39 p.m., resident #48 sat in his/her room recliner in a calm manner with his/her call light within reach.

During an interview on 3/14/13 at 1:30 p.m., Licensed Nursing Staff E verified resident #48's clinical record between December 2011 and March 2013 lacked evidence of an attempt at a gradual dose reduction in the dose of Zoloft.

The facility failed to ensure resident #48 did not receive unnecessary medication when the resident received Zoloft 100 mg every night since 10/21/10 without an attempt at a gradual dose reduction from December 2011 until March 2013.

- Resident #4's 3/13/13 physician's orders included diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord) and major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness). The physician's orders included an order for Celexa 40 mg (milligrams) orally daily for depression with a start date of 10/4/11.

Resident #4's 2/3/13 Significant Change in Status MDS (Minimum Data Set) Assessment reported short and long term memory issues and severely impaired decision making skills. The MDS reported that according to staff, the resident experienced no signs of depression. The MDS reported the resident received antidepressant medication for 7 of the 7 observation days.

Resident #4's Psychotropic Medication Use CAA (Care Area Assessment) summary reported the

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F 329	Continued From page 3 resident received Celexa to treat depression. Resident #4's 2/12/13 care plan instructed staff to monitor for signs of adverse consequences such as suicidal ideation while the resident received Celexa for depression. Review of resident #4's clinical record between December 2011 and March 2013 lacked evidence that the physician ordered a gradual dose reduction for the use Celexa with an original start date of 10/4/11. During an observation on 3/14/13 at 8:23 a.m., resident #4 sat upright in a high-backed wheelchair, appeared alert with his/her eyes opened, and ate over 50% of his/her breakfast as Direct Care Staff G assisted him/her to eat. During an interview on 3/14/13 at 1:30 p.m., Licensed Nursing Staff E verified resident #4's clinical record between December 2011 and March 2013 lacked evidence of an attempt at a gradual dose reduction in the dose of Celexa. The facility failed to ensure resident #4 did not receive unnecessary medication when the resident received Celexa 40 mg orally daily since 10/4/11 without an attempt at a gradual dose reduction from December 2011 until March 2013.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 4 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility had a census of 54 residents with 10 residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and director of nursing for 2 of 10 sampled residents related to the use of antidepressants without attempts at gradual dose reductions. (#48 and #4) Findings included: - Resident #48's 2/7/13 physician's orders included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The physician's orders included an order for Zoloft 100 mg (milligrams) orally every night with a start date of 10/21/10. Resident #48's 2/17/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident experienced severely impaired cognition, displayed no signs of depression, and received antidepressant medication for 7 of the 7 observation days.	F 428		

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Resident #48's 2/26/13 care plan instructed staff to monitor the resident for adverse consequences and side effects such as suicidal ideation and mental status changes while the resident received Zoloft to treat depression.

Review of resident #48's consultant pharmacist's monthly medication reviews between 12/26/11 and 2/19/13 lacked evidence that the pharmacist reported to the physician and/or director of nursing a need for a gradual dose reduction for Zoloft with an original start date of 10/21/10

During an observation on 3/12/13 at 3:39 p.m., resident #48 sat in his/her room recliner in a calm manner with his/her call light within reach.

During an interview on 3/14/13 at 3:54 p.m., Consultant B reported a lack of awareness of the need to report to the physician and/or director of nursing to attempt a gradual dose reduction for resident #48's order of Zoloft.

The facility failed to ensure the consultant pharmacist reported irregularities for resident #48 to the physician and/or director of nursing related to the resident received Zoloft 100 mg every night since 10/21/10 without an attempt at a gradual dose reduction from December 2011 until March 2013.

- Resident #4's 3/13/13 physician's orders included diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord) and major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and

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hopelessness). The physician's orders included an order for Celexa 40 mg (milligrams) orally daily for depression with a start date of 10/4/11.

Resident #4's 2/3/13 Significant Change in Status MDS (Minimum Data Set) Assessment reported short and long term memory issues and severely impaired decision making skills. The MDS reported that according to staff, the resident experienced no signs of depression. The MDS reported the resident received antidepressant medication for 7 of the 7 observation days.

Resident #4's Psychotropic Medication Use CAA (Care Area Assessment) summary reported the resident received Celexa to treat depression.

Resident #4's 2/12/13 care plan instructed staff to monitor for signs of adverse consequences such as suicidal ideation while the resident received Celexa for depression.

Review of resident #4's consultant pharmacist's monthly medication reviews between 12/26/11 and 2/19/13 lacked evidence that the pharmacist reported to the physician and/or director of nursing the need for a gradual dose reduction for Celexa with an original start date of 10/4/11.

During an observation on 3/14/13 at 8:23 a.m., resident #4 sat upright in a high-backed wheelchair, appeared alert with his/her eyes opened, and ate over 50% of his/her breakfast as Direct Care Staff G assisted him/her to eat.

During an interview on 3/14/13 at 3:54 p.m., Consultant B reported a lack of awareness of the need to report to the physician and/or director of

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F 428	Continued From page 7 nursing to attempt a gradual dose reduction for resident #4's order for Celexa. The facility failed to ensure the consultant pharmacist reported irregularities for resident #4 to the physician and/or director of nursing related to the resident the resident received Celexa 40 mg orally daily since 10/4/11 without an attempt at a gradual dose reduction from December 2011 until March 2013.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 8 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary environment to help prevent the transmission of disease and infection when staff failed to clean resident #64's room in a sanitary manner, housekeeping staff lacked knowledge of the type of organism that required staff to place resident #64 in isolation, and staff failed to clean reusable resident equipment between resident use which affected two residents, #23 and #64, one of which staff placed on contact precautions. Findings included: - During an observation on 3/13/13 at 9:13 a.m., a green sign in front of resident #64's room instructed visitors to see the charge nurse prior to entry to the room. During an interview on 3/13/13 at 9:14 a.m., Licensed Nursing Staff C reported staff placed the green sign on resident #64's room to indicate	F 441		

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staff used contact isolation precautions while in the room.

During an observation on 3/13/13 at 9:54 a.m., Housekeeping Staff E wore an isolation gown and gloves to clean resident #64's room, sprayed the resident's toilet and grab bars with a disinfectant from a spray bottle, and immediately wiped the disinfectant off the toilet and grab bars with a rag.

Review of the disinfectant label on the spray bottle indicated the title as "Bathroom Disinfectant Cleaner" but the label lacked instructions for use.

During an interview and observation on 3/13/13 at 10:04 a.m., Staff E reported the spray bottle held diluted disinfectant obtained from a larger bottle stored in a janitor's closet. Staff E unlocked the janitor closet to reveal the larger "Bathroom Disinfectant Cleaner" bottle. Staff E reported a lack of knowledge of the organism that required staff to place resident #64 in contact isolation.

Review of the label for the larger container of "Bathroom Disinfectant Cleaner" revealed instructions to leave the disinfectant on surfaces for 10 minutes then wipe off.

During an interview on 3/13/13 at approximately 10:10 a.m., Staff E verified he/she failed to follow the disinfectant's instructions to clean resident #64's items in his/her bathroom.

During an interview on 3/13/13 at 11:34 a.m., Housekeeping Staff F reported the facility expected staff to follow the disinfectant's instructions to clean residents' rooms, including resident #64. Staff F reported that the nursing

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department reported to the housekeeping department when staff placed a resident in contact, droplet, or airborne precautions, but failed to identify the type of organism that caused the resident to need isolation. Staff F verified rooms isolated for organisms, such as Clostridium Difficile and MRSA, required different cleaning techniques.

The facility had several policies instructing housekeeping staff how to clean isolation rooms, such as a July 2004 "Isolation Rooms (VRE) [Vancomycin-Resistant Enterococcus]" policy, a "Isolation Rooms (MRSA) [Methicillin-Resistant Staphylococcus Aureus]" policy, and a 2/14/11 "Precautions for Patients with Clostridium Difficile", each with specific and different instructions to sanitize isolated residents' rooms.

During an interview on 3/13/13 at 2:58 p.m., Administrative Nursing Staff A verified that the nursing department failed to report to different departments, such as housekeeping, the type of organism that required staff to place residents on isolation, such as resident #64.

The facility failed to ensure a safe, sanitary environment to help prevent the transmission of disease and infection when staff failed to clean resident #64's room in a sanitary manner and housekeeping staff lacked knowledge of the type of organism that required staff to place resident #64 in isolation.

- During an observation on 3/12/13 at 9:54 a.m., Direct Care Staff D obtained resident #23's blood pressure, temperature, pulse oximetry, and pulse using a reusable blood pressure machine. Staff

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D failed to clean the blood pressure cuff and pulse oximeter after leaving resident #23's room.

During an observation on 3/12/13 at 9:56 a.m., Direct Care Staff D walked into resident #64's room with the same contaminated reusable blood pressure machine. Staff D obtained resident #23's blood pressure, temperature, pulse oximeter, and pulse using the reusable blood pressure machine and failed to clean the blood pressure cuff and pulse oximeter after use.

A sign outside of resident #64's room instructed visitors to see the charge nurse prior to entry to the room.

During an interview on 3/13/13 at 9:14 a.m., Licensed Nursing Staff C reported that staff placed the green sign on resident #64's room to indicate staff used contact isolation precautions while in the room. Staff C reported resident #64 needed isolation due to MRSA (Methicillin-Resistant Staphylococcus Aureus) in his/her urine.

During an interview on 3/13/13 at 2:53 p.m., Administrative Nursing Staff A stated that staff did not use a dedicated equipment such as a blood pressure cuff for residents on isolation, such as resident #64, and the facility expected staff to clean reusable equipment between resident use.

The facility's "Isolation and Precaution Guidelines" policy, revised on 10/11/10, instructed staff that "equipment will be dedicated to the patient so that there will be no sharing until the patient is free of the multidrug-resistant organism... items included and are not limited

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F 441	Continued From page 12 to... blood pressure cuff sleeves, thermometers, and any other item which requires repeated usage for care the patient. If the patient requires equipment that is not single patient use, the item must be cleaned according to the manufacturers recommendations immediately following use. The staff member using the item is responsible for cleaning." The facility failed to ensure a safe, sanitary environment to help prevent the transmission of disease and infection when staff failed to clean reusable resident equipment between resident use which affected residents #23 and #64 and failed to follow the facility's policy for reusable equipment for resident #64 in contact precautions.	F 441		